AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I hereby authorize the **Area Office on Aging of Northwestern Ohio** to release copies of all information comprising the entire record for the individual named below, to

Name: **RECORDS DEPOSITION SERVICE, INC.**

Address: **PO BOX 5054** City: **SOUTHFIELD** State: **MI** Zip Code: **48086-5054**

Phone Number: **P: 248-357-3330 F: 248-357-3337**

including, but not limited to:

Final Diagnoses	Operative Records	Emergency Room Treatments
Discharge Summaries	Pathology Reports	Therapy Notes
Histories	Progress Notes	Clinical Notes
Physical Examinations	Physician's Orders	Medication Records
Consultation Reports	Office Notes	Evaluations
Diagnostic Images	All computer entries/notes/ electronic mail	HIV/AIDS Results
Billing/Account Records		Correspondence regarding patient
Insurance Records	Patient forms and questionnaires	Pathology Specimens

The use/disclosure of the information is needed for the following purpose: **FOR DISCOVERY BEFORE TRIAL**

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immune deficiency syndrome (AIDS), information concerning testing or treatment of AIDS and AIDS-related conditions, drug or alcohol abuse, human immunodeficiency virus (HIV), drug-related conditions, alcoholism and/or psychiatric/psychological conditions, including specifically, but not limited to, those records contemplated by 42 U.S.C. §290 dd-2. Review of the records is also hereby authorized.

To assist in the identification and location of these records, I am providing the following information:

Name:_____

Client Identification No. (CIN): _____

Social Security No.:_____

Date of Birth:_____

I hereby authorize the use of a photocopy of this release as an original.

I understand I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Privacy Officer of the Area Office on Aging of Northwestern Ohio, Inc. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in six (6) months.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that the **Area Office on Aging of Northwestern Ohio** cannot condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I understand I may inspect or copy the information to be used or disclosed, as provided in C.F.R. 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure, and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the **Area Office on Aging of Northwestern Ohio**.

_____
Witness

_____
Patient (or legal representative)

If signed by legal representative, relationship to patient:

_____

Date:_____

**This release is intended to comply with the Health Information Portability and Accountability Act (HIPAA) and Ohio Revised Code §5101.271.